

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10257				10253			
MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH				CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>HARFORD</b>	
c. LENGTH OF STAY IN 1b <b>1 1/2 DAYS</b>		d. STREET ADDRESS <b>R. D. #2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>		First <b>Amspacher</b>		Last <b>Amspacher</b>		4. DATE OF DEATH <b>September 12 1961</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-10-61</b>	
9. AGE (In years last birthday) <b>1</b>		10. IF UNDER 1 YEAR <b>1</b>		11. IF UNDER 24 HRS. <b>12</b>		12. CITIES OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIES OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EUGENE Amspacher</b>		14. MOTHER'S MAIDEN NAME <b>EVELYN Ritz</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANOXIA</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYALINE MEMBRANE DISEASE</b> (c) <b>PREMATURITY</b>		18. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>9-10</b> 19 <b>61</b> to <b>9-12</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9-11</b> 19 <b>61</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>M. B. Norman M.D.</b>		22b. DATE SIGNED <b>9-12-61</b>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-14-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Potosi Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Glen Rock, Pa. R.D. 2</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Dan H. Hertenstein</b>		24a. REC'D BY REGISTRAR <b>SEP 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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Handwritten notes and signatures, including "10523" and "10523" repeated multiple times, along with illegible signatures and dates.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
HARFORD		MARYLAND		MD		HARFORD	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22 days		Harre de Grace		202 Wilson St			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Middle Last				Month Day Year			
William E Boyd				September 8 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 28, 1877	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
83 yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Farmer (Ret.)				Farm		Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
John M. Boyd				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
No				213-01-8838			
17. INFORMANT				Address			
Mrs. W.E. Boyd, Harre de Grace, Md.				202 Wilson St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				22 days			
443X DUE TO							
Conditions, if any, which gave rise to immediate cause (b)							
Hypertension							
DUE TO (c)							
arterio sclerosis, cardiovascular disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1961, to Sept 8, 1961, that (I) (we) last saw the deceased alive on Sept 8, 1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Edward J. Simon				9/8/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
EDWARD J. SIMON				Harre de Grace			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
Burial				9/12/61			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Spesutia Cemetery				Perryman, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
John G. Tarring				25b. REGISTRAR'S SIGNATURE			
John G. Tarring				Aberdeen, Md.			
DATE				SEP 13 '61			

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Sept. 24, 1977

SOS Wilson St.

41-01-8076 Mrs. W.E. Boyd, Suite 20 Grace, Md.

Enlist 102301  
Tanning, David J.  
Averdon, Md.  
Specialty Center  
Tanning, David J.  
Averdon, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10259

## CERTIFICATE OF DEATH

10255

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN 1b <u>14 days</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>518 Walker St</u>															
<b>3. NAME OF DECEASED</b> (Type and print name) <u>Albert Eugene Clements</u>				<b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>2</u> Year <u>1961</u>															
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>19 Aug 61</u>													
<b>9. AGE</b> (In years last birthday) <u>14</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.					<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NA</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NA</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Harford, Maryland</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>James Clements</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Roberta <del>Brothers</del> Brothers</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)													
<b>16. SOCIAL SECURITY NO.</b> <u>NA</u>		<b>17. INFORMANT</b> <u>Mother</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>staph aureus</u> type unknown (c) <u>associated with prematurity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>19 Aug</u> <u>1961</u> to <u>2 Sept</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>2 Sept</u> <u>1961</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <u>Malcolm McLean, M.D.</u>				<b>22b. DATE SIGNED</b> <u>9/2/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Malcolm McLean, M.D.</u>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>9/7/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bel Air Memorial Gardens</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Bel Air Maryland</u>													
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John E. Harring - Aberdeen, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>SEP 6 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10256						10256					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)					
a. COUNTY <b>HARFORD</b>						a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVE &amp; GRACE</b>						b. COUNTY <b>HARFORD</b>					
c. LENGTH OF STAY in 1b <b>1 hr. 35 min.</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STREET</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD MEMORIAL HOSPITAL</b>						d. STREET ADDRESS <b>Rt. 2 Box 1934</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <b>COCHRAN</b>						Month Day Year <b>SEPT. 3 19 61</b>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<b>M</b>		<b>W</b>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9-3-61</b>		<b>1 35</b>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
								<b>HARFORD, MARYLAND U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM J. COCHRAN</b>						14. MOTHER'S MAIDEN NAME <b>AGNES RIGSBY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>						16. SOCIAL SECURITY NO.					
17. INFORMANT <b>William J. Cochran</b>						Address <b>Street, Maryland.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Congenital defect</b> <b>759.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1'35"</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/3/61</b> , 19 <b>61</b> , to <b>9/3/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/3/61</b> , 19 <b>61</b> , and that death occurred at <b>6:11</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Dudley Phillips M.D.</b>						22b. DATE SIGNED <b>9/3/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dudley Phillips M.D.</b>						22d. ADDRESS <b>DARLINGTON 2nd</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Sept. 4, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial</b>				23d. LOCATION (City, town or county) (State) <b>Abingdon, Harford, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son</b>						25a. REC'D BY REGISTRAR <b>SEP 7 '61</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

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William J. Cochran, Secretary, Maryland.

Serial 2000, 1901  
Howard E. McCombs & Son  
Volunteer, 1901-1902  
Cochran Memorial  
Volunteer, Maryland  
Volunteer, Hartford, Maryland.



**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**10261**

**10257**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Harry</u> First <u>Crawford</u> Middle <u>Left</u> Last <u>15</u>		<b>4. DATE OF DEATH</b> <u>Sept. 15</u> 19 <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29/1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	
11. BIRTHPLACE (State or foreign country) <u>Gallatin, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fred Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Luella Mundis</u> Address <u>Street Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X</u> DUE TO <u>Cardiorespiratory failure</u>		(b) <u>Chronic silico-fibrotic disease of the lungs</u>	
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		(c) <u>with cor pulmonale</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Sheldon B. Bowers, Jr</u>		22b. DATE SIGNED <u>9/16/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>128 E. Courtland Bel Air, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>State Ridge</u>		23b. DATE THEREOF <u>Sept. 19, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gork Co</u>		23d. LOCATION (City, town, or county) (State) <u>Penn.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Charlottesville</u>		25a. REC'D BY REGISTRAR <u>SEP 22 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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*[Faint, illegible text, likely a contract or document, covering the majority of the page.]*

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

10262

10258

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURC DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARVIN ANDREWS CRESWELL</b>				4. DATE OF DEATH Month Day Year <b>September 22 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 18, 1895</b>	9. AGE (in years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Creswell</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Gorrell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT Address <b>Mrs. Ewald Brokemyr, Belair, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> <b>420.1</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/19/61</b> 19 to <b>9/22/61</b> 19, that (I) (we) last saw the deceased alive on <b>9/22/61</b> 19, and that death occurred at <b>6:45</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Alfred W. Grigoloit MD.</b>				22b. DATE <b>9/22/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Alfred W. Grigoloit</b>	
22d. ADDRESS <b>608 Salmon St. Haver de Grace, Md.</b>							
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-25-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DARLINGTON</b>		23d. LOCATION (City, town, or county) (State) <b>DARLINGTON, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Perkins</b>				24a. REC'D BY REGISTRAR <b>SEP 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinnis</b>	

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10263

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

10259

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 HAVRE DE GRACE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 So. STOKES, ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HOWARD BURNA DENHAM</b>				4. DATE OF DEATH Month Day Year <b>SEPT. 30 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 29 1893</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN DOYLE DENHAM</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET WATTERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Address <b>Mrs. Helen G. Denham, HAVRE DE GRACE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO <b>Coronary Occlusion</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/3-38</b> 19 <b>61</b> , to <b>SEPT. 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>9/29</b> and that death occurred at <b>9:25</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>OCT. 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FRIENDS CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>CECIL CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b> ADDRESS <b>MD. HAVRE DE GRACE</b>				25a. REC'D BY REGISTRAR <b>OCT 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

10366

CERTIFICATE OF DEATH

10366

10366

NAME OF DECEASED: [illegible]

[illegible signature]

CHIEF

[illegible signature]



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Form Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

10264  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Churchville</u> c. LENGTH OF STAY IN lb <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; if hospital, give name and admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Churchville</u> d. STREET ADDRESS <u>Aldino Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BOBBIE</u> Middle <u>XXXXXX</u> Last <u>Joe Dotson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1941</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garbage Disposal</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clyde Dotson</u>		14. MOTHER'S MAIDEN NAME <u>Marie Mahan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>162-32-2599</u>	
17. INFORMANT <u>Mrs. Louise Dotson, R#1, Aberdeen, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>Auto accident</u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> a.m. <u>9-7</u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) <u>Edgewood Singer Road</u>		20f. (City or town) (County) (State) <u>Hq md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lois P Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u>	
EXAMINER'S NAME (Type) <u>Goird P Palmer, md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9-7-61</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/11/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harford Mem. Gardens</u>	22d. LOCATION (City, town, or country) (State) <u>R.D. Aberdeen, Maryland</u>
23. FUNERAL DIRECTOR <u>John G. Tarring</u>		24a. REC'D BY REGISTRAR <u>SEP 13 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>John G. Tarring</u>		24c. REGISTRAR'S SIGNATURE <u>John G. Tarring</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10265 - DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10261

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamlet-Grace</i>		c. LENGTH OF STAY IN 1b <i>41 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>1 Box 254</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>M.</i> Last <i>Edwards</i>		4. DATE OF DEATH Month <i>9</i> Day <i>10</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1, 1884</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Feed Store</i>	
11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Maurice Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Lydia Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>** **</i>	
17. INFORMANT <i>Joycel Edwards</i> Address <i>Granddaughter</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Posterior myocardial infarction</i> 420.1 DUE TO (b) <i>Posterior Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Generalized arteriosclerotic Cardio-vascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 days</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral pneumonia, lower lobes</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1st, 1961</i> to <i>Sept. 10th, 1961</i> , that (I) <i>we</i> lost saw the deceased alive on <i>Sept. 10th, 1961</i> , and that death occurred at <i>9:15 pm</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Loo</i> M.D.		22b. DATE SIGNED <i>Sept. 11th, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>		22d. ADDRESS <i>Haure de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/13/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>RD. Bel Air, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Sarnig</i> ADDRESS <i>Tarring Funeral Home Aberdeen, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 15 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hane</i>	

10801

OFFICE OF THE ATTORNEY GENERAL

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U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

THE ATTORNEY GENERAL  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10266

10262

1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Aberdeen Rural #2</i> c. LENGTH OF STAY IN life <i>life</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Rt #22</i>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Aberdeen Rural #2</i> d. STREET ADDRESS <i>Rt #22</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>William Herbert Greenland</i>				4. DATE OF DEATH Month Day Year <i>Sept. 30th 1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 18 - 1879</i>	
9. AGE (In years birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer, self emp.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>William Greenland</i>				14. MOTHER'S MAIDEN NAME <i>Fau Pullum</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Maudie V. Greenland - Aberdeen #2 Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (b) <i>Arteriosclerosis of heart &amp; CV Disease</i> (c) <i>6 yrs</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>6 yrs</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 19</i> to <i>Sept 6</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Sept 20</i> , 19 <i>61</i> , and that death occurred at <i>7:00 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Ralph Horky</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Sept 27 '61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Ralph Horky</i>				22d. ADDRESS <i>Churchville Md Post 61</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept. 23/1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Smith Chapel Methodist</i>		23d. LOCATION (City, town or county) (State) <i>Aberdeen #2 Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Farring - Aberdeen. Md.</i>				25a. REC'D BY REGISTRAR DATE <i>SEP 27 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

10882

10882

(M)

(I)

Handwritten text, likely a list or index, starting with "Handwritten" and "List".

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G295 9/21/61 iwk

10267

## CERTIFICATE OF DEATH

Reg. Dist. No. 10263

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>Lifelong</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lee</u> Last <u>Hooper</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1888</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>11</u> Min.	IF UNDER 24 HRS. Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Edward C. Hooper</u>				14. MOTHER'S MAIDEN NAME <u>Mary Orem</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-2170</u>		17. INFORMANT <u>James Hooper, Hyde, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> <u>CVA 3 yrs. ago</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>CVA 3 yrs. ago</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Harford Md</u>	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Sept.</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harford, Md.</u> DATE SIGNED <u>9-16-61</u> ACTUAL SIGNATURE <u>William A. Tyson M.D.</u> PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>				ADDRESS <u>Berwyn Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 1961</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneel</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

**DECEASED**  
Name: *John Doe*  
Date of Death: *10/15/1918*  
Place of Death: *Home*  
Cause of Death: *Pneumonia*  
Age: *45*  
Sex: *Male*  
Occupation: *Teacher*  
Residence: *123 Main St, Baltimore, Md*  
Physician: *Dr. J. Smith*  
Burial Place: *Greenwood Cemetery*  
Funeral Home: *None*  
Manner of Death: *Natural*  
Signature: *[Signature]*  
Date: *10/20/1918*

11

Vertical text on the right margin, likely a filing or archival reference.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22a Film G295 9/18/61 1wk

## CERTIFICATE OF DEATH

10268

Reg. Dist. No. 10264

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>E.</b> Last <b>Hueitt</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>4</b> Year <b>19 61</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 17, 1908</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>61</b>		IF UNDER 24 HRS. Months <b>4</b> Days <b>19</b> Hours <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William G. Hueitt</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>			
14. MOTHER'S MAIDEN NAME <b>Mary B. Jackson</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Pauline E. Tasco</b> Address <b>Aberdeen Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia with Acidosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal Insufficiency</b> DUE TO (c) <b>Diabetes Mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> Month <b>19</b> Day <b>19</b> Year <b>19 61</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>569 Revolution Street</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July 14, 1961</b> , to <b>Sept. 4, 1961</b> , that I last saw the deceased alive on <b>Sept. 3, 1961</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George T. Stansbury</b>				DATE SIGNED <b>9/6/61</b>			
PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>				ADDRESS (Street, city or town, state) <b>569 Revolution Street, Havre de Grace, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>Sept. 7, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenspring</b>		22d. LOCATION (City, town, or county) (State) <b>Havre de Grace R.D., Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McCombs Jr.</b>				ADDRESS <b>Abingdon Md.,</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 11 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

CERTIFICATE OF DEATH

182523

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		1955		10:00 AM		Home		Dr. J. Smith		J. Doe	
Name of Informant		Relationship		Occupation		Address		City		State		County		Zip		Telephone		Signature		Date		Time	
Jane Doe		Wife		Homemaker		123 Main St		Baltimore		Maryland		Baltimore		21201		(410) 555-1234		J. Doe		1955		10:00 AM	
Name of Physician		Address		City		State		County		Zip		Signature		Date		Time		Signature		Date		Time	
Dr. J. Smith		123 Main St		Baltimore		Maryland		Baltimore		21201		J. Doe		1955		10:00 AM		J. Doe		1955		10:00 AM	

1  
FOR STATE  
HEALTH DEPT.

TO DISSEMINATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH				Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
10269				10265			
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>24</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		d. STREET ADDRESS <u>550 Revolution Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ADELLA</u> Middle <u>C</u> Last <u>LISBY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1889</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harve de Grace, Md</u>		11. BIRTHPLACE (State or foreign country) <u>Harve de Grace, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilkinson Carney</u>		14. MOTHER'S MAIDEN NAME <u>Ella Legarr</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>218-05-0856</u>		17. INFORMANT Address <u>550 Revolution St Harve de Grace, Md</u> <u>Mrs Ella M. Bordley</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Insufficiency complicating</u> <u>90400</u> DUE TO (b) <u>Surgical Fixation of Fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>of Hip under Penthal-N2O, or anesthesia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) <u>Fell to floor</u>					
20c. TIME OF INJURY Month, Day, Year <u>11 - 9/2 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Harve de Grace HARFORD Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. S. Fisher</u>		EXAMINER'S NAME (Type) <u>R. S. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/4/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 7, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, Maryland</u>	
23. FUNERAL DIRECTOR <u>Elmer E. Bullock</u>		ADDRESS <u>Harve de Grace, Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>	



10802

10802

M

M



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10270

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items #14 & 22 - Film 297 - 10/2/61-mnb

Reg. #10281

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford</b> c. LENGTH OF STAY IN 1b <b>1-ann de Grace</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore Pipe Line</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>5x-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.D. 1 Grantville, Pa.</b> d. STREET ADDRESS <b>R.D. 1 Grantville, Pa.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George</b>		4. DATE OF DEATH <b>8:30 AM</b> Month <b>9</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-03 1904</b> 9. AGE (In years - last birthday) <b>56</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Shermantale, Pa. U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Jacob Glou</b>		14. MOTHER'S MAIDEN NAME <b>BLANCHE LENTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>176-01-5160</b>	
17. INFORMANT <b>Louis J. Wimer</b>		Address <b>Office Mgr. R.D. Havre de Grace, Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emascination train</b> <b>912.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into crane</b>	
20c. TIME OF INJURY Month, Day, Year <b>9-22-1961</b>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore Pipe Line</b>	20f. (City or town) (County) (State) <b>Havre de Grace, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-22-61</b>	
EXAMINER'S NAME (Type) <b>Gerald C Palmer - M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>Bella is, Md.</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL <b>Sept 22 1961</b>		22b. DATE THEREOF <b>Sept 22 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CHESTNUT GROVE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MARYSVILLE, PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Bailey</b>		24a. REC'D BY REGISTRAR <b>SEP 25 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			

Sent to Henry Fisher, Route 1, Harrisburg, Pa. N.2nd. St. Harrisburg, Penna.

17

10250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MAYNARD STATE OF HEALTH - BALTIMORE, MD

10250

Form with multiple sections for medical history, symptoms, and examination findings. Includes checkboxes for various conditions and a large area for the physician's signature and notes.

10250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

1

10271

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10266

1. PLACE OF DEATH a. COUNTY <i>Maryland</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> c. LENGTH OF STAY IN 1b <i>44 yrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford House</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY <i>Maryland</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> c. STREET ADDRESS <i>726 Fountain</i> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lizzie Walker Miller</i>		4. DATE OF DEATH Month <i>9</i> Day <i>15</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/13/1879</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months <i>3</i> Days <i>1</i> Hours <i>1</i> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		12. BIRTH PLACE (County & State, or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Andrew K. Walker</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Shank</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Lillian M. Foy</i>		18. ADDRESS <i>120 Bay Blvd. Harford House Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>420.0</i> DUE TO <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <i>cardiac arrhythmia</i> <i>adren. stress syndrome</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Senility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1961</i> <i>3 months</i> <i>1 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/15/61</i> to <i>9/15/61</i> , that (I) (we) last saw the deceased alive on <i>9/15/61</i> , and that death occurred at <i>9/15/61</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Lillian M. Foy</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Phonograph Co.</i>		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>		DATE <i>SEP 20 '61</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10272

## CERTIFICATE OF DEATH

10267

Item 7 Film G293 9/21/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		
c. LENGTH OF STAY in 1b <u>3 yrs.</u>			d. STREET ADDRESS <u>Wakefield Meadows</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wakefield Meadows</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Petrone Mitchell</u>			4. DATE OF DEATH <u>September 13 1961</u>		
5. SEX <u>P</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18 1876</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Retired</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Deceased</u>		
14. MOTHER'S MAIDEN NAME <u>Deceased</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Margaret Lock Boehler</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-13</u> , 19 <u>61</u> , to <u>9-13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9-13-61</u> , 19 <u>61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Gerald C Palmer</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>9-14-61</u>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			22d. ADDRESS <u>Bel Air, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>9-15-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>	
23d. LOCATION (City, town or county) <u>Bel Air Rd</u>		(State) <u>MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Aschenbrenner</u> ADDRESS <u>637 W. 4th St.</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		DATE <u>SEP 18 1961</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G296 9/26/61 lwk

## CERTIFICATE OF DEATH

Reg. Dist. No. 10268

10273

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>York</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural White Hall</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home</b>				d. STREET ADDRESS <b>Fawn Grove</b>			
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Rebecca</b> Last <b>Morris</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-1882</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fawn Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reed Almoney</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kisiner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Harvey 1366 W. King St., York, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
21. I certify that I attended the deceased from <b>Sept 13, 1961</b> , to <b>Sept 23, 1961</b> , that I last saw the deceased alive on <b>Sept 23, 1961</b> , and that death occurred at <b>8:40</b> M, from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <b>Edward W. Hyson</b>				ADDRESS (Street, city or town, state) <b>Fawn Grove, Pa.</b> DATE SIGNED <b>9-23-61</b>			
PHYSICIAN'S NAME (Type) <b>Edward W. Hyson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fawn Grove Meth. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fawn Grove, York Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Williams</b>				ADDRESS <b>Stewartstown, Penna.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 26 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

## 5525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ABERDEEN</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>M.</b> Last <b>Ogonowski</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-78</b>
9. AGE (In years lost birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>83</b> Days <b>29</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH unknown</b>		14. MOTHER'S MAIDEN NAME <b>Anna unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Family</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b> DUE TO <b>Cerebral vascular apoplexy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO <b>Arterio-sclerosis</b> (c) <b>Arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sept 25</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 25</b> 19 <b>61</b> to <b>Sept 29</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>Sept 29</b> 19 <b>61</b> , and that death occurred at <b>2:40</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>E. J. Simon</b>		22b. DATE SIGNED <b>9-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. J. Simon</b>		22d. ADDRESS <b>same as home</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE THEREOF <b>10-2-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		23d. LOCATION (City, town, or county) (State) <b>Balto.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mc Culby Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Baltimore Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>		DATE <b>OCT 3 '61</b>	

W. H. Allen

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. No. 10270

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abingdon, Rural</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>T.</b> Last <b>Peaker</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May, 17, 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
13. FATHER'S NAME <b>Stephen Peaker</b>		14. MOTHER'S MAIDEN NAME <b>Sarah White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-09-6191 C</b>	
17. INFORMANT <b>Mattie V. Peaker</b>		Address <b>Abingdon Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with metastases</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5</b> , 19 <b>61</b> , to <b>Sept 17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Sept 18</b> , 19 <b>61</b> , and that death occurred at <b>12:30 p.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Fred O. Hodus</b> M.D.		DATE SIGNED <b>Sept 19 61</b>	
PHYSICIAN'S NAME (Type) <b>Fred O. Hodus</b>		ADDRESS (Street, city or town, state) <b>Edgewood Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 23, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Joppa, R.D., Harford, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son</b>		24a. REC'D BY REGISTRAR <b>SEP 26 '61</b>	
ADDRESS <b>Abingdon Md.,</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES M. ...		Male		45	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
Jan 15, 1912		Home		Heart Disease	
TIME OF DEATH		MANNER OF DEATH		OCCUPATION	
10:30 AM		Natural		Farmer	
RESIDENCE		BIRTHPLACE		EDUCATION	
No. 123 Main St., Baltimore, Md.		Maryland		High School	
MARITAL STATUS		RELIGION		SPECIAL OCCASIONS	
Married		Roman Catholic		None	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
Dr. J. H. ...		J. H. ...		St. Mary's Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE	
Jan 15, 1912		10:30 AM		Home	

4

RECEIVED

THE STATE DEPARTMENT OF HEALTH  
BALTIMORE, MD.  
JAN 15 1912



VS. A15ME  
5M 9/60

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10271

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KALMIA</b>		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. RT. #1 6 MILES NORTH OF BELAIR</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAY THOMAS PETTY</b>		4. DATE OF DEATH <b>SEPT. 28 1961</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 15, 1937</b>	
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EMMETT C. PETTY</b>		14. MOTHER'S MAIDEN NAME <b>NORA RICHARDSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>215-34-6853</b>	
17. INFORMANT <b>EMMETT C. PETTY</b>		Address <b>DARLINGTON, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONCUSSION, BRAIN &amp; SKULL FRACTURE</b> <b>816 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>AND FRACTURE 2ND AND 3RD CERVICAL VERTEBRAL AND SEVERED SPINAL CORD</b> (c) <b>CORD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>FRACTURES MANDIBLE, MAXILLA, LT RADIUS, ULNA, FEMUR, LT CHEST</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>AUTO ACCIDENT - RAN INTO LT SIDE TRACTOR TRAILER</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:00 a.m. SEPT 28, 1961</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HIGHWAY US1</b>		20f. (City or town) <b>KALMIA, BELAIR, HARFORD, Md</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-1-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NEW BRIDGE</b>		22d. LOCATION (City, town, or country) <b>RISING SUN, Cecil Co., MD.</b> (State)	
23. FUNERAL DIRECTOR <b>John A. Harbours, DELTA, Pa.</b>		24a. REC'D BY REGISTRAR <b>OCT 2 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

10277

10272

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford County Jail</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u> d. STREET ADDRESS <u>Thomas Run Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Don</u> <u>Thomas</u> <u>Pitsinger</u>			4. DATE OF DEATH Month Day Year <u>September 11</u> <u>1961</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept. 25, 1925</u>		9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Rife Wright Pitsinger</u>		
14. MOTHER'S MAIDEN NAME <u>Lottie Eddie</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give year or dates of service) <u>W.W.II</u>		
16. SOCIAL SECURITY NO. <u>108-18-3832</u>			17. INFORMANT (wife) <u>Mrs. Helen Marie Pitsinger</u> Address <u>Route #1, Box 88 Fallston, Maryland</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>974X Suicide by hanging</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self in Jail</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p.m. <u>9-11</u> <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jail</u>	
20f. (City or town) <u>Belt Air</u>		20g. (County) <u>Har</u>		20h. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>Belt Air, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 14, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Int. Zion Methodist Cemetery</u>	
				22d. LOCATION (City, town, or country) (State) <u>Fountain Green, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway &amp; Will Pains St. Belt Air, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Library of Congress  
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for \$1.00  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10278

10273

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 20</u>				d. STREET ADDRESS <u>Box 20</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenton M. Presberry</u>				4. DATE OF DEATH Month Day Year <u>Sept. 17 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>December 5, 1885</u>		9. AGE (In Years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolteacher/retired Board of Education</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Darlington, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hazzard Presberry</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Spriggs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-32-0887</u>		17. INFORMANT <u>Mrs. Earl O. Presberry, Darlington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>42011</u> DUE TO (b) <u>Cerebral Thrombosis</u> (c) <u>Hypertensive-Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 20, 1960</u> to <u>Sept. 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 17, 1961</u> , and that death occurred at <u>12:25 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Stansbury, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury, M. D.</u>				22d. ADDRESS <u>569 Revolution St. Havre de Grace, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Darlington, Harford Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock, Havre de Grace, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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hypertensive-thrombotic heart disease

Cerebral Thrombosis

Hypertensive-thrombotic heart disease

Aug. 12, 1951

Aug. 12, 1951

Sept. 17, 51

George F. Stansbury, M.D.

George F. Stansbury, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10279

CERTIFICATE OF DEATH

10274

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 HOURS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELAIR</u>	
3. NAME OF DECEASED (Type or print) <u>IRVING</u>		d. STREET ADDRESS <u>338 WEBSTER</u>	
First Middle Last <u>IRVING</u> <u>REISER</u>		4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 11, 1918</u>
9. AGE (In years lost birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEWIS REISER</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA PEIT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W. W. 11 214-20-6270</u>	
17. INFORMANT <u>Mrs. Morris Berman- 3714 Howard Pk Avenue</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden onset</u> <u>6 hours</u> <u>2-3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19th, 1961</u> to <u>Sept. 19th, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 19th, 1961</u> , and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>9/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>211 N. Union Ave. Haver de Grace Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rodfe Zedek</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol. Levinson &amp; Bros. Inc. 6010 Reist Road</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>28</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		d. STREET ADDRESS <u>Box 32</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robin</u> Middle <u>Ryan</u> Last <u>Ryan</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-61</u>
9. AGE (In years lost birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Thomas Richard Ryan</u>		14. MOTHER'S MAIDEN NAME <u>Dickey Bronscomb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Thomas Ryan</u>		Address <u>Aberdeen Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 472.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pharyngitis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>~ 5 hours</u> <u>5 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 22</u> 19 <u>61</u> to <u>Sept 26</u> 19 <u>61</u> , that (I) <u>was</u> last saw the deceased alive on <u>Sept 26</u> 19 <u>61</u> , and that death occurred at <u>4</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>B.J. Plunkett, Jr.</u>		22b. DATE SIGNED <u>9/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.J. Plunkett, Jr.,</u>		22d. ADDRESS <u>Aberdeen Maryland.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 29, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.,</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Abingdon, Md.,</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>OCT 2 '61</u>			

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DEPARTMENT OF DEATH

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Handwritten notes and signatures at the top of the page, including names like "H. J. ...", "H. J. ...", and "H. J. ...".

Handwritten notes and signatures in the middle section, including names like "H. J. ...", "H. J. ...", and "H. J. ...".

Handwritten notes and signatures at the bottom of the page, including names like "H. J. ...", "H. J. ...", and "H. J. ...".

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10281

CERTIFICATE OF DEATH

Reg. Dist. No.

10276

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa Md</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa Md</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt 1 Box 99</b>				d. STREET ADDRESS <b>1 Rt 1 Box 99</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willard</b> Middle <b>McLennan</b> Last <b>Sewell</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-1899</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Phillip Sewell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Norris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-12-5704</b>		17. INFORMANT <b>Mrs Annette Sewell</b> Address <b>Box 99 Joppa Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs-</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <b>o. 11</b> p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>61</b> , to <b>Sept 5</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Sept. 5</b> , 19 <b>61</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Kingsville, Md.</b> DATE SIGNED <b>9-5-61</b>							
ACTUAL SIGNATURE <b>William H. Tyson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William H. Tyson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-8-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Christian Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>HARFORD Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lasscha Funeral Home 2401 Belair Road</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 11 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10282  
FOR STATE HEALTH DEPT.

10277

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs</u>				d. STREET ADDRESS <u>1 Md Route 22</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md Route 22</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Benjamin Westwood Smith</u>				4. DATE OF DEATH <u>September 22 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-1894</u>	
9. AGE (in years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Benjamin W Smith Sr</u>				14. MOTHER'S MAIDEN NAME <u>Betty Titlow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-07-3427</u>			
17. INFORMANT <u>Mrs Catherine Smith</u>				Address <u>RT 1 Bel Air Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Cerebrum</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self - shot gun</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9-22-61</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bel Air Har - Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dorrell C Palmer</u>				CHIEF MEDICAL EXAMINER <u>Bel Air, Md</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9-22-61</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Michael's Luth Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Bel Air Md</u>	
23. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>				ADDRESS <u>740 Bel Air Road</u>			
24a. REC'D BY REGISTRAR <u>SEP 25 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10283 CERTIFICATE OF DEATH 10278

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>		c. LENGTH OF STAY IN <b>42 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Watervale Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Seher Sterbak</b>		4. DATE OF DEATH <b>September 17 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1872</b>
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>8</b> Days <b>17</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Vincent Seher</b>		14. MOTHER'S MAIDEN NAME <b>Clara Hunger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT (Son) <b>Frank V. Sterbak, Jr.</b>		Address <b>Watervale Rd. Fallston, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ _____ } DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>9-17</b> 19 <b>61</b> to <b>9-17</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>9-17</b> 19 <b>61</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Israel C Palmer</b> M.D.		22b. DATE SIGNED <b>9-17-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerald C Palmer MD</b>		22d. ADDRESS <b>Bel Air, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 20, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cem.</b>		23d. LOCATION (City, town or county) <b>Fallston, Harf. Co., Md.</b> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>		25a. REC'D BY REGISTRAR <b>SEP 20 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10284  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10279  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b> c. LENGTH OF STAY IN 1b <b>Aberdeen Proving Ground</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAH, Aberdeen Proving Ground, Maryland</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b> d. STREET ADDRESS <b>2761 L Rodman Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>EZER</b> First Middle Last <b>TAYLOR</b>		4. DATE OF DEATH Month Day Year <b>SEPTEMBER 28 1961</b>		9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negroid</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Clay County, Alabama</b>	
13. FATHER'S NAME <b>JIM JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>LULA CURLEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>2761 L Rodman Rd</b> <b>Mrs Johnnie Burch (Daughter) Aberdeen PG, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		22d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) <b>(discharged)</b> attended the deceased from <b>27 September 1961</b> to <b>28 September 1961</b> that (I) <b>(saw)</b> last saw the deceased alive on <b>27 September 1961</b> and that death occurred at <b>7:15AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>John E Hoffman</b>		22b. DATE SIGNED <b>28 September 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN E HOFFMAN, CAPT, MC</b>	
22d. ADDRESS <b>US Army Hospital, Aberdeen Proving Ground,</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>9/29/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	
23d. LOCATION (City, town or county) <b>Rockledge - Alabama</b>		23e. (State) <b>MO.</b>		25a. REC'D BY REGISTRAR <b>OCT 3 '61</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Garring - Aberdeen, Md.</b>		24b. ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

10285 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10280

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Richmond</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Richmond</u>		
c. LENGTH OF STAY IN 1b <u>83x-3</u>			d. STREET ADDRESS <u>2515 Gittings Lane</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>George R. Terrill</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
4. DATE OF DEATH Month Day Year <u>September-16 19 61</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/1914</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Waynesboro Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>George C. Terrill</u>			14. MOTHER'S MAIDEN NAME <u>Annie Somers Terrill</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>ad 2</u>		
17. INFORMANT <u>Ms Annie Terrill, Waynesboro Va.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture R femur, fracture pelvis</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>9-16 19 61</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Saugeton Bridge</u>	20f. (City or town) <u>Hartford</u>	(County) <u>Rich</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel A in md</u>		
EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
			DATE SIGNED <u>9-16-61</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/19/61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Augusta Mem Park Waynesboro Va.</u>	
22d. LOCATION (City, town, or country) <u>Waynesboro Va.</u>		(State) <u>Va.</u>			
23. FUNERAL DIRECTOR (Name - Type - Address) <u>Per. Louell Houghton, Jr. 234 S. Wayne</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10287  
10282  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence prior to admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Harre-de-Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street/address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.D. # 2</u>	
3. NAME OF DECEASED (Type or print) <u>Harrison M. Wood</u>		4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Luther Sheyk. 713 Revolution City</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-sclerotic vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 30, 1961</u> to <u>Sept. 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 2, 1961</u> and that death occurred at <u>9:00PM</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>Paulo Pinto</u> M.D.		22b. DATE SIGNED <u>9/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paulo Pinto, M.D.</u>		22d. ADDRESS <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grove Cemetery</u>		23d. LOCATION (City, town or county) <u>Aberdeen, Maryland</u> (State) <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		25c. ADDRESS <u>  </u>	

10382

10382

(M)

PAUL WHITE

Oct. 6, 1982

Carpenner (Self)

Self-employed

Virginia

U.S.A.

Unknown

Unknown

No

Aug. 30, 1982

9:00 PM

Sept. 2, 1982

Paulo Pineda, M.D.

Trinity Hospital Home  
Aberdeen, Md.

Aberdeen, Maryland

SEP

9/1/82

John G. Tarter

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10288

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>NEW YORK</b> b. COUNTY <b>10288</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAUCE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>7 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAM</b> First Middle Last <b>ZEKIND</b>		4. DATE OF DEATH <b>SEPTEMBER 12 1961</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>UNKNOWN</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Grocer</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Michael Zelkind son</b> Address <b>11 Chestnut Hill Dr. Murray N.Y.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation and leukemoid infiltration of lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>204.0</b> DUE TO (b) <b>Chronic lymphatic leukemia</b> (c) <b>Marked secondary anemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>?</b> <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 11th 1961</b> to <b>Sept. 12th 1961</b> , that (I) <b>was</b> last saw the deceased alive on <b>Sept. 12th 1961</b> , and that death occurred at <b>3:40</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward C. Loo</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Sept. 12th 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		22d. ADDRESS <b>211 N. Union Ave., Hauce de Grace, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Sept. 14, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Maryland, Prince Georges Co. Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Morris, Jr.</b> ADDRESS <b>9701 Church Ave. N.W.</b>		25a. REC'D BY REGISTRAR <b>SEP 15 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>R. Madison Mitchell</b>		25c. REGISTRAR'S SIGNATURE <b>O. Paul S. Harris</b>	

(M)

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(I)

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(M)

10388

CELLULOSE DE DRAIN

10388

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "CELLULOSE" and "DRAIN" are visible.]*